Washington State Department of Social & Health Services

HRSA Health & Recovery Services Administration

General Information for Authorization

Org	1. 508	Service Type	2. SCAN
Client Information			
Name	3. CLIENT NAME	Client ID	4. 123456789WA
Living Arrangements	5.	Reference Auth #	6.
Provider Information			
Requesting NPI #	7. 1123456789	Requesting Fax #	8. XXXXXXXXXX
Servicing NPI #	9. 1123456789	Name	10. SERVICING PROVIDER NAME
Referring NPI #	11. 1123456789	Referring Fax #	12. XXXXXXXXXX
Service Start Date:	13.		14. N/A
Service Request Information			
Description of service being requested: 15. PET-CT SCAN		16. N/A	17. N/A
18. Serial / NEA# N/A		19. N/A	

20. Code Qualifier	21. National Code	22. Mod	23. # Units/Days Requested	24. $ Amount Requested	25. Part # (DME Only)	26. Tooth or Quad #
C	CPT			N/A	N/A	N/A
P	A9552		1	N/A	N/A	N/A

Medical Information			
Diagnosis Code	27. ICD-9	Diagnosis name	28.
Place of service	29.		
30. Comments:			

www.WaProviderOne.org

Instructions to fill out the General Information for Authorization form, DSHS 13-835

FIELD	NAME	ACTION
		ALL FIELDS MUST BE TYPED.
1	Org required	Enter the Number that Matches the Program/Unit for the Request 500 - Division of Alcohol and Substance Abuse (DASA) 501 - Dental 502 - Durable Medical Equipment (DME) 509 - Economic Services Administration (ESA) (DSHS) 504 - Home Health 505 - Hospice 506 - Inpatient Hospital 507 - Juvenile Rehabilitation Administration (JRA) (DSHS) 508 - Medical 509 - Medical Nutrition 510 - Mental Health 511 - Outpt Proc/Diag 513 - Physical Medicine & Rehabilitation (PM & R) 514 - Aging and Disability Services Administration (ADSA) 515 - Transportation 516 - Miscellaneous
2	Service Type required	Enter the letter(s) in all CAPS that represent the service type you are requesting. AA Ambulatory Aids BB Bath Bench BEM Bath Equipment (misc) BGM Blood Glucose Monitors BGS Bone Growth Stimulator BP Breast Pumps BS Bariatric surgery BSS2 Bariatric surgery stage 2 C Commode CI Cochlear Implants CIERP Cochlear Implant Ext Repl Prts CSC Commode/Shower Chair CWN Crowns DASA DASA DEN Dentures EN Enteral Nutrition ESA ESA FSFS Floor Sitter/Feeder Seat HB Hospital Beds HEA Hearing Aids HH Home Health HSPC Hospice IPT Infusion/Parental Therapy ITA Inpatient admission - ITA JRA JRA LTAC LTAC MC Medication MISC Miscellaneous MN Medical Nutrition MWH Manual Wheelchair - Home MWNF Manual Wheelchair - NF O Other ODC Orthodontic ODME Other DME OOS Out of State OP Ostomy Products OS Orthopedic Shoes OTC Orthotics PAS PAS PDN Private Duty Nursing PHY Pharmacy PL Patient Lifts PMR PM and R PROS Prosthetics PRS Prone Standers PSY Psychotherapy PTL Partial PWH Power Wheelchair - Home PWNF Power Wheelchair -- NF PWNF Power Wheelchair - NF PHYS Physician Services R Respiratory RBS Rebases RE Room equipment RLNS Relines RM Readmission S Surgery SBS Specialty Beds/Surfaces SC Shower chairs SCAN MRI/PET Scans SF Standing Frames SGD Speech Generating Device SSIP Short Stay (In-Patient) T Therapies (PT/OT/ST) TRN Transportation TU TENS Units US Urinary Supplies V Vision VNSS Vagus nerve stimulator surgery VOL Inpatient admission-Voluntary WDCS Wound/decubiti care supplies

3	Name: Required.	Enter the last name, first name, and middle initial of the patient you are requesting authorization for.
4	Client ID: Required.	Enter the client ID = 9 numbers followed by WA. For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending): ▪ You will need to contact DSHS at 1-800-562-3022 and the appropriate extension of the Authorization Unit (See contact section for further instructions). ▪ A reference PA will be built with a placeholder client ID. ▪ If the PA is approved – once the client ID is known – you will need to contact DSHS either by fax or phone with the Client ID. ▪ The PA will be updated and you will be able to bill the services approved.
5	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc.
6	Reference Auth #	If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI #: Required.	The 10 digit numeric number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#	The fax number of the requesting provider.
9	Servicing NPI #: Required.	The 10 digit numeric number that has been assigned to the billing/servicing provider by CMS.
10	Name	The name of the billing/servicing provider.
11	Referring NPI #	The 10 digit numeric number that has been assigned to the referring provider by CMS.
12	Referring Fax #	The fax number of the referring provider.
13	Service Start Date	The date the service is planned to be started if known.
15	Description of service being requested: Required.	A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).
18	Serial/NEA#: Required for all DME repairs.	Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA# to access the x-rays for this request.
20	Code Qualifier: Required.	Enter the letter corresponding to the code from below: T - CDT Proc Code C - CPT Proc Code D - DRG P - HCPCS Proc Code I - ICD-9/10 Proc Code R - Rev Code N - NDC-National Drug Code S - ICD-9/10 Diagnosis Code
21	National Code: Required.	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier	When appropriate enter a modifier.
23	# Units/Days Requested: Required.	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific Billing Instructions for the appropriate unit/day designation for the service code entered).
24	$ Amount Requested: Required.	Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Billing Instructions and fee schedules for assistance) Must be entered in dollars & cents with a decimal (e.g. $400 should be entered as 400.00.
25	Part # (DME only): Required for all "By Report" codes requested.	Enter the manufacturer part # of the item requested.

26	Tooth or Quad#: Required for dental requests	Enter the tooth or quad number as listed below: QUAD 00 – full mouth 01 – upper arch 02 – lower arch 10 – upper right quadrant 20 – upper left quadrant 30 – lower left quadrant 40 – lower right quadrant Tooth # 1-36, A-T, AS-TS, 51-82 and SN
27	Diagnosis Code	Enter appropriate diagnosis code for condition.
28	Diagnosis name	Short description of the diagnosis.
29	Place of Service	Enter the appropriate two digit place of service code.
30	Comments	Enter any free form information you deem necessary.

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		ALL FIELDS MUST BE TYPED
1	**Org required**	Enter the Number that Matches the Program/Unit for the Request ~~500 - Division of Alcohol and Substance Abuse (DASA)~~ ~~501 - Dental~~ ~~502 - Durable Medical Equipment (DME)~~ ~~509 - Economic Services Administration (ESA) (DSHS)~~ ~~504 - Home Health~~ ~~505 - Hospice~~ ~~506 - Inpatient Hospital~~ ~~507 - Juvenile Rehabilitation Administration (JRA) (DSHS)~~ **508 - Medical** ~~509 - Medical Nutrition~~ ~~510 - Mental Health~~ ~~511 - Outpt Proc/Diag~~ ~~513 - Physical Medicine & Rehabilitation (PM & R)~~ ~~514 - Aging and Disability Services Administration (ADSA)~~ ~~515 - Transportation~~ ~~516 - Miscellaneous~~
2	**Service Type required**	Enter the letter(s) in all CAPS that represent the service type you are requesting. ~~AA~~ ~~Ambulatory Aids~~ ~~BB~~ ~~Bath Bench~~ ~~BEM~~ ~~Bath Equipment (misc)~~ ~~BGM~~ ~~Blood Glucose Monitors~~ ~~BGS~~ ~~Bone Growth Stimulator~~ ~~BP~~ ~~Breast Pumps~~ ~~BS~~ ~~Bariatric surgery~~ ~~BSS2~~ ~~Bariatric surgery stage 2~~ ~~C~~ ~~Commode~~ ~~CI~~ ~~Cochlear Implants~~ ~~CIERP~~ ~~Cochlear Implant Ext Repl Prts~~ ~~CSC~~ ~~Commode/Shower Chair~~ ~~CWN~~ ~~Crowns~~ ~~DASA~~ ~~DASA~~ ~~DEN~~ ~~Dentures~~ ~~EN~~ ~~Enteral Nutrition~~ ~~ESA~~ ~~ESA~~ ~~FSFS~~ ~~Floor Sitter/Feeder Seat~~ ~~HB~~ ~~Hospital Beds~~ ~~HEA~~ ~~Hearing Aids~~ ~~HH~~ ~~Home Health~~ ~~HSPC~~ ~~Hospice~~ ~~IPT~~ ~~Infusion/Parental Therapy~~ ~~ITA~~ ~~Inpatient admission - ITA~~ ~~JRA~~ ~~JRA~~ ~~LTAC~~ ~~LTAC~~

Field	Name	Action
		~~MC~~ ~~Medication~~ ~~MISC~~ ~~Miscellaneous~~ ~~MN~~ ~~Medical Nutrition~~ ~~MWH~~ ~~Manual Wheelchair - Home~~ ~~MWNF~~ ~~Manual Wheelchair - NF~~ ~~O~~ ~~Other~~ ~~ODC~~ ~~Orthodontic~~ ~~ODME~~ ~~Other DME~~ ~~OOS~~ ~~Out of State~~ ~~OP~~ ~~Ostomy Products~~ ~~OS~~ ~~Orthopedic Shoes~~ ~~OTC~~ ~~Orthotics~~ ~~PAS~~ ~~PAS~~ ~~PDN~~ ~~Private Duty Nursing~~ ~~PHY~~ ~~Pharmacy~~ ~~PL~~ ~~Patient Lifts~~ ~~PMR~~ ~~PM and R~~ ~~PROS~~ ~~Prosthetics~~ ~~PRS~~ ~~Prone Standers~~ ~~PSY~~ ~~Psychotherapy~~ ~~PTL~~ ~~Partial~~ ~~PWH~~ ~~Power Wheelchair - Home~~ ~~PWNF~~ ~~Power Wheelchair - NF~~
		~~PWNF~~ ~~Power Wheelchair - NF~~ ~~PHYS~~ ~~Physician Services~~ ~~R~~ ~~Respiratory~~ ~~RBS~~ ~~Rebases~~ ~~RE~~ ~~Room equipment~~ ~~RLNS~~ ~~Relines~~ ~~RM~~ ~~Readmission~~ ~~S~~ ~~Surgery~~ ~~SBS~~ ~~Specialty Beds/Surfaces~~ ~~SC~~ ~~Shower chairs~~ **SCAN** **MRI/PET Scans** ~~SF~~ ~~Standing Frames~~ ~~SGD~~ ~~Speech Generating Device~~ ~~SSIP~~ ~~Short Stay (In-Patient)~~ ~~T~~ ~~Therapies (PT/OT/ST)~~ ~~TRN~~ ~~Transportation~~ ~~TU~~ ~~TENS Units~~ ~~US~~ ~~Urinary Supplies~~ ~~V~~ ~~Vision~~ ~~VNSS~~ ~~Vagus nerve stimulator surgery~~ ~~VOL~~ ~~Inpatient admission-Voluntary~~ ~~WDCS~~ ~~Wound/decubiti care supplies~~
3	**Name: Required.**	Enter the last name, first name, and middle initial of the patient you are requesting authorization for.
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5	**Living Arrangements**	~~Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc~~. NOT REQUIRED FOR PET-CT SCANS
6	**Reference Auth #:**	If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	**Requesting NPI #: Required.**	The 10 digit numeric number that has been assigned to the requesting provider by CMS.
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13	**Service Start Date:**	The date the service is planned to be started if known.
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21	**National Code: Required.**	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	**Modifier:**	When appropriate enter a modifier.
23	**# Units/Days Requested: Required.**	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific Billing Instructions for the appropriate unit/day designation for the service code entered).
24	**$ Amount Requested: Required.**	NOT REQUIRED FOR PET-CT SCANS ~~Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Billing Instructions and fee schedules for assistance) Must be entered in dollars & cents with a~~

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		~~decimal (e.g. $400 should be entered as 400.00.~~
25	**Part # (DME only): Required for all "By Report" codes requested.**	NOT REQUIRED FOR PET-CT SCANS ~~Enter the manufacturer part # of the item requested.~~
26	**Tooth or Quad#: Required for dental requests**	NOT REQUIRED FOR PET-CT SCANS ~~Enter the tooth or quad number as listed below:~~ ~~QUAD~~ ~~00—full mouth~~ ~~01—upper arch~~ ~~02—lower arch~~ ~~10—upper right quadrant~~ ~~20—upper left quadrant~~ ~~30—lower left quadrant~~ ~~40—lower right quadrant~~ ~~Tooth # 1-36, A-T, AS-TS, 51-82 and SN~~
27	**Diagnosis Code:**	Enter appropriate diagnosis code for condition.
28	**Diagnosis name**	Short description of the diagnosis.
29	**Place of Service**	Enter the appropriate two digit place of service code. **Use 11 for office; 22 for out-patient hospital**
30	**Comments:**	Enter any free form information you deem necessary.